MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01771

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County: Harford

City or town: White Hall R.F.D. 2nd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: White Hall R.F.D. 2nd

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Bettie N. Anderson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: J. Thomas Anderson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 24 - 1854

8. AGE: Years	Months	Days	If less than one day
90	7	20	..... hrs. ..... min.

9. Birthplace: Rocks Harford Co Md

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Nicholas Hope Nelson

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Hannah Hope

15. Birthplace: Rocks, Md.

16. Informant: Mrs. Thomas J. Anderson

Address: White Hall, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: FEB 18 1945 (month) (day) (year)

Cemetery or crematory: Bethel

Location: White Hall, Md.

18. Funeral director: Howard S. Mathias

Address: White Hall Md

19. Feb. 17 1945 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14 1945, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Feb 14 1945

and that I last saw h[illegible] alive on Feb 13 1945

Immediate cause of death	DURATION
Colitis acute	
Due to: Gastric Enteritis	
Due to:	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Grace B. Free M.D. M. D. or other

Address: Churchville Md. Date signed: Feb 15 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01772

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 350 Bourbon St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 350 Bourbon St
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME May Fields Baldwin

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Monroe Baldwin
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1855

8. AGE: Years	Months	Days	If less than one day
89	11	28	hrs. min.

9. Birthplace Penn (Town, county, and state)
10. Usual occupation Home Duties
11. Industry or business

FATHER
12. Name Cornelius P. Fields
13. Birthplace Penn

MOTHER
14. Maiden name Mary S. Fields
15. Birthplace Penn

16. Informant Mr. Harford Baldwin
Address Havre de Grace Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 13 1945 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace, Md.

18. Funeral director R. Madison Mitchell
Address Havre de Grace Md.

19. Feb. 12 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1945 at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 1944 to Feb. 10, 1945 and that I last saw h.. alive on Feb. 10, 1945

Immediate cause of death	DURATION
Cardiac Insufficiency	
Due to Chronic Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D., or other
Address Havre de Grace Md Date signed Feb 12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

01773

CERTIFICATE OF DEATH

Reg. Dist. No. 193

1. PLACE OF DEATH:

County Harford

City or town Darlington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford

City or town Darlington R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sallie Blaney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Widowed

6.(b) Name of husband or wife Frank Blaney

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) About 1860

8. AGE: Years	Months	Days	If less than one day
about 85			hrs. ..... min.

9. Birthplace Harford Co Md

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Housekeeping

FATHER 12. Name Don't know

13. Birthplace

MOTHER 14. Maiden name Alice Lewis

15. Birthplace Harford Co Md

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 14 1945 (month) (day) (year)

Cemetery or crematory Glenwood Hill

Location Rocks Md

18. Funeral director W Elwood Webb

Address Forest Grove Pa

19. Feb 14 1945 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1945, at 4 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946, to Feb 10 1945

and that I last saw her alive on Feb 9 1945

	DURATION
Immediate cause of death Congestive Heart Failure	2 days
Due to Arteria-sclerotic C-V Disease	5 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis G. Hunt M.D.

M. D. or other

Address Cardiff Md Date signed 2/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

01774

Reg. Dist. No. 182

1. PLACE OF DEATH

County Harford

City or town Benson (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 wks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Phoebe E. Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife Theodious Brown

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1875

8. AGE: Years	Months	Days	If less than one day
70	✓	4	hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation House Keeper

11. Industry or business Domestic

FATHER 12. Name James Bond

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Emma ✓

MOTHER 15. Birthplace Md.

16. Informant Mrs Nara Brown

Address Benson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 11, 1945 (month) (day) (year)

Cemetery or crematory Lakeview

Location Benson Md.

18. Funeral director Vogelgesang & Goss

Address Benson, Md.

19. 2/10 (Date rec'd by registrar) 1945 Priscilla Foxwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8th 1945, at 11.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4th 1945 to Feb. 8th 1945 and that I last saw her alive on Feb. 4th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. F. Van Fidler M.D. or other

Address Bel Air, Md. Date signed Feb 9-1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

Reg. Dist. No. 0177 18 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Harford

City or town Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 6 months

Hospital, institution, or street address where death occurred:
Station Hospital, Aberdeen Proving Ground, Md.

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Michigan County Calhoun

City or town Battle Creek
(If outside city or town limits, write RURAL and give nearest town)

Street No. 328 W. Van Buren St.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME MAX STUART CAMPBELL

3. (b) Social Security Number 366-07-4531

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife Norma E. Campbell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 19 April 1907

8. AGE: Years	Months	Days	If less than one day
37	9	24	..... hrs. ..... min.

9. Birthplace Battle Creek, Michigan
(Town, county, and state)

10. Usual occupation Mechanic - Auto

11. Industry or business

FATHER
12. Name Roy D.
13. Birthplace Michigan

MOTHER
14. Maiden name Lutie Rand
15. Birthplace Minnesota

16. Informant The Surgeon

Address Station Hospital, APG, Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Feb 14 1945 (month) (day) (year)

Cemetery or crematory Hebbler's Funeral Home

Location W. Michigan ave Battle Creek Mich.

18. Funeral director Howard K. McComas Home

Address Aberdeen Maryland

Feb 14 19 45 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 February 19 45 at 12:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 February 19 45 to 13 Feb 19 45 and that I last saw him alive on 13 February 19 45

Immediate cause of death	DURATION
Thrombosis, coronary, artery, acute	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results. Myocardial infarction

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE A D Hoffman M.D.
A. D. HOFFMAN 1st Lt. MC M. D. or other

Address Station Hospital, APG, Md. Date signed 13 Feb 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115)

01776

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Aylesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, institution, or street address where death occurred:
near Wheelers School House
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aylesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. near Wheelers School House
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Wilson Hunt Daughton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): January 16 1945

8. AGE: Years | Months | Days: 18 | If less than one day: hrs. min.

9. Birthplace: Aylesville, Harford Co., Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: Charles Ross Daughton
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden name: Lena Annie Rigdon
15. Birthplace: Harford Co. Md.

16. Informant: Charles Ross Daughton
Address: Aylesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 5 1945 (month) (day) (year)
Cemetery or crematory: St Marys
Location: Aylesville Md

18. Funeral director: W. Hanlon Webb
Address: Fawn Grove Pa

Feb 5 1945 Thomas R. Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3 1945, at 8 a.m. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 16 1945 to Feb 3 1945 and that I last saw h... alive on February 1 1945

Immediate cause of death	DURATION
Aspiration asphyxia	
Due to: Ruptured cyst in naso-pharynx.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Josiah A. Hunt, M.D.
M. D. or other
Address: Cardiff, Md. Date signed 2/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

01777

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Whiteford Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Whiteford Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Robert H. Davis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Anna E. Davis

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Jan. 30 - 1871

8. AGE:

Years	Months	Days	If less than one day
74	0	7	...hrs. ...min.

8. Birthplace: Harford Co. Md.
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER
12. Name: John Davis
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden name: Elizabeth Dicke
15. Birthplace: Harford Co. Md.

18. Informant: Bertha Davis Hughes

Address: Whiteford, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 10-1945 (month) (day) (year)

Cemetery or ~~cremetery~~: Southern Cemetery

Location: Dublin, Md.

18. Funeral director: Hubert P. Harkins

Address: Delta, Pa.

19. Feb. 10 1945 (Date rec'd by registrar) Carl E. Krantz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7 1945, at 11 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944 to Feb 7 1945

and that I last saw him alive on Feb 7 1945

Immediate cause of death	DURATION
Bronchopneumonia	
Due to	
Due to	
Other conditions: Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Josiah A. Arnt M.D.
M. D. or other

Address: Cardiff Md Date signed 2/8/45

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01778
Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? 1 hr. and 50 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 415. N. Stokes Street
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Henry Morgan DiMarco

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 27, 1944

8. AGE: Years	Months	Days	If less than one day
	2 Mos.		hrs. min.

9. Birthplace: Havre de Grace, Harford Co., Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Henry DiMarco
13. Birthplace: Havre de Grace, Md.

MOTHER
14. Maiden name: Dorothy L. Cullum
15. Birthplace: Aberdeen, Maryland

16. Informant: Henry DiMarco - Father
Address: 415 N. Stokes St., City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 2 - 1945 (month) (day) (year)
Cemetery or crematory: Calvary
Location: Emmorton Harford Co. Md

18. Funeral director: Handy Fanning Sons
Address: Aberdeen Md

19. 3-1 (Date rec'd by registrar) 19 45 A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-26-45 19 9:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/25 19 45 to 2/26 19 45
and that I last saw h... alive on 2/26 19 45

Immediate cause of death	DURATION
Lobar Pneumonia	
Due to Streptococcus Throat	
Due to Accidental Failure	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles J. Foley M.D. M. D. or other
Address: Havre de Grace Md Date Signed: 3/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33a)

CERTIFICATE OF DEATH

01779

Reg. Dist. No. 186

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days.
Hospital, Institution, or street address where death occurred:
Harford Memorial Hosp.
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME Catherine Dolan.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: John E. Dolan.
6.(c) If alive, give age: 68 years
7. Birth date of deceased (mo., day, yr.): Nov. 28, 1867 1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77 77	2	5		

9. Birthplace: England (Town, county, and state) England.
10. Usual occupation: Housewife
11. Industry or business: Own home.
FATHER 12. Name: Jacob Clark
13. Birthplace: England
MOTHER 14. Maiden name: Unknown
15. Birthplace: England
16. Informant: Deceased + Mr. John E. Dolan
Address: Aberdeen Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 6 1945 (month) (day) (year)
Cemetery or crematory: St Frances
Location: Abingdon Md.
18. Funeral director: Henry Jarvis Sons
Address: Aberdeen Md.
19. Feb 5 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 3 1945, at 6 57 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-27 1945 to 2-3 1945 and that I last saw h.e.r. alive on 2-3 1945

Immediate cause of death	DURATION
Cardiorespiratory Failure	2 days
Due to: Hypostatic Congestion of Lungs	4 days
Due to: Senile Debility	
Other conditions: Pyelitis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Charles W Pigon M.D. M. D. or other
Address: Harford Memorial Hosp Havre de Grace Md. Date signed: 2-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01780

Reg. Dist. No. 182

1. PLACE OF DEATH:

County: Harfor

City or town: Near - Bel Air Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Bel Air Md (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Evalena H Durham

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Jacob C Durham

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 1 1867

8. AGE:	Years	Months	Days	If less than one day
	77			hrs. min.

9. Birthplace: Harford (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Hanna

13. Birthplace: Harford Co

MOTHER — 14. Maiden name: Lucretia Meehan

15. Birthplace: Harford Co

16. Informant: Jacob C Durham

Address: Bel Air

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 21 1945 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Fountain Green

18. Funeral director: Dean & Foster

Address: Bel Air Md

19. 2/21 1945 (Date rec'd by registrar) Priscilla Fawood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 18 1945 at 1 30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 7 1945 to Feb 18 1945 and that I last saw her alive on Feb 18 1945

	DURATION
Immediate cause of death: Coronary Occlusion	2 hrs
Due to: ✓	
Due to:	
Other conditions: ✓	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. P. Snodgrass M. D. or other

Address: Darlington Md Date signed 2/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

01781

Reg. Diat. No. 185

THIS CORPORATE LIMITS OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 hrs. 40 min.
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? 7 hrs. 40 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Edgewood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma M. Fletcher

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	INFANT

6.(b) Name of husband or wife: None
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1945

8. AGE: Years | Months | Days | If less than one day: 7 hrs. 40 min.

9. Birthplace Havre de Grace, Harford, Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Frank John Fletcher
13. Birthplace Penna.

MOTHER 14. Maiden name Lottie Irene Griffin
15. Birthplace Harford Co., Md.

16. Informant Mrs. Frank J. Fletcher
Address Edgewood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 27, 1945 (month) (day) (year)
Cemetery or crematory Emory Cem.
Location Harford Co., Md.

18. Funeral director H. S. Bailey
Address Darlington, Md.

19. Feb. 25 19 45 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 19 45 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 24 19 45 to Feb 24 19 45 and that I last saw h[illegible] alive on Feb 24 19 45

Immediate cause of death	DURATION
Pulmonary atelectasis	6 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE J. Ralph Hurley M.D. M. D. or other
Address Glen Burnie, Md. Date signed Feb 26

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

01782

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County: Harford

City or town: Cherry Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 53 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Cherry Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mamie C. Grafton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Wm A Grafton

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July — 1863

8. AGE: Years 81 | Months 7 | Days — | If less than one day: ..... hrs. ..... min.

9. Birthplace: Kalmia Harford Co Md.

(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER

12. Name: Walter Cunningham

13. Birthplace: Balto Md.

MOTHER

14. Maiden name: Maria Trautner

15. Birthplace: Md.

16. Informant: Hayward A Grafton

Address: Magnolia Arkansas.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb 27-45 (month) (day) (year)

Cemetery or crematory: Deer Creek Harford Co.

Location: Chestnut Hill Md

18. Funeral director: Martin E Kurtz

Address: Churchville Md

19. 2/27 1945 Priscilla Lowood

(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 25 1945 at 10:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1st 1945 to Feb 25 1945

and that I last saw her alive on Feb 25 - 1945

Immediate cause of death	DURATION
Chr. Myocardeal Disease	18 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill Md Date signed 2/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-E)

CERTIFICATE OF DEATH

01783

Reg. Diat. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 Minutes
Hospital, Institution, or street address where death occurred:
Fountain Green Hospital
How long in hospital or institution? 33 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. 64 East Bel Air Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charlotte Grier

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 15, 1945

8. AGE: Years | Months | Days | If less than one day: 33 min. hrs.

9. Birthplace: Bel Air, Harford County, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: William H. Grier
13. Birthplace: Milford, Del.

MOTHER
14. Maiden name: Mary Bradley
15. Birthplace: Jarrettsville, Maryland

16. Informant: Mrs. Mary Bradley Grier
Address: 64 East Bel Air Ave., Aberdeen, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 16 - 45 (month) (day) (year)
Cemetery or crematory: Odd Fellows Cemetery
Location: Milford Del

18. Funeral director: Williams Funeral Home (Carey)
Address: 646 Bel Air Ave Aberdeen

19. 2/16 1945 Priscilla Forwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 15, 1945 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15, 1945 to Feb. 15 1945
and that I last saw her alive on Feb. 15 1945

Immediate cause of death	DURATION
Congenital heart disease.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Nature of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill, Maryland Date signed: 2-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

01784

CERTIFICATE OF DEATH

Reg. Dist. No. 184

1. PLACE OF DEATH:
County: Harford
City or town: Cardiff
(If outside city or town limits, write RURAL and give nearest town)
How long in above place at death? 45 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Cardiff
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jesse J. Healy

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: Dora J. Healy
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec. 20 - 1860
8. AGE: Years: 84 Months: 2 Days: 2 If less than one day: hrs. min.
9. Birthplace: Harford Co. Md. (Town, county, and state)
10. Usual occupation: Dentist
11. Industry or business:
FATHER 12. Name: William Healy
13. Birthplace: Harford Co. Md.
MOTHER 14. Maiden name: Elizabeth Carr
15. Birthplace: Harford Co. Md.
16. Informant: Kenneth Healy
Address: 1202 E. 36th St. Balto. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 25 1945 (month) (day) (year)
Cemetery or crematory: Slate Ridge cemetery
Location: Delta, Pa.
18. Funeral director: Hubert P. Harkins
Address: Delta, Pa.
19. Feb. 25 1945 (Date rec'd by registrar) Carl E. Krough Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22 1945, at 2 45 A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 21 1945 to February 22 1945
and that I last saw h.. alive on February 22 1945

	DURATION
Immediate cause of death: Myocardial Failure	Feb 21
Due to: Coronary Sclerosis	
Due to: Generalized arterio-Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Josiah A. Hunt M.D.
M. D. or other
Address: Cardiff, Md. Date signed 2/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

CERTIFICATE OF DEATH

01785

Reg. Dist. No. 180

1. PLACE OF DEATH:
County: Harford
City or town: Joppa
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 1 year & 4 Mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Joppa
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mr Aubrey Elbert Hylton

3.(b) Social Security Number: 230-01-5955

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nina L. Hylton
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): Dec 13 1910

8. AGE: Years	Months	Days	If less than one day
34	1	26	....hrs. ....min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Radio Technician
11. Industry or business
FATHER — 12. Name: Aubrey E. Hylton
FATHER — 13. Birthplace: Floyd Co Virginia
MOTHER — 14. Maiden name: Irene Whitlow
MOTHER — 15. Birthplace: Virginia
18. Informant: Nina L. Hylton
Address: Joppa, R.D. Md
17. Disposition: Interment (Burial, cremation, or removal. Which?) Date thereof: Feb 12 1945 (month) (day) (year)
Cemetery or crematory: Richardson + Co.
Location: Christiansburg, Va
16. Funeral director: Howard R. McCormas & Son
Address: Abingdon Maryland
19. Feb 12 1945 (Date rec'd by registrar) Marie M Mouldale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 9 1945 at 1150 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-2 1945 to 2-9 1945 and that I last saw h[illegible] alive on 2-9 1945

	DURATION
Immediate cause of death: coronary occlusion	
Due to: Chronic Glomerulonephritis	1 year
Due to:	
Other conditions: hypertension retinitis	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Fred O Hodous, M.D (M. D. or other)
Address: Edgewood, Md. Date signed 2-9-44

(M) (1) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

01786

Reg. Dist. No. 181

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 117 Bogues St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 117 Bogues

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Susie M. Jacobs

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband: Charles H. Jacobs

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 21 - 1885

8. AGE: Years	Months	Days	If less than one day
59	4		hrs. min.

9. Birthplace: West Va

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER — 12. Name: Mr. Lewis F. Martin

FATHER — 13. Birthplace: Aberdeen Md

MOTHER — 14. Maiden name: Susie Cole

MOTHER — 15. Birthplace: Aberdeen Md.

16. Informant: Mrs. Clarence W. Martin

Address: 117 Bogues St Aberdeen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 16 - 1945 (month) (day) (year)

Cemetery or crematory: Babes

Location: Aberdeen Md.

18. Funeral director: Henry Tanning Sons

Address: Aberdeen Md

19. Feb. 15 1945 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 13 1945, at 10:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12 1945 to Feb. 13 1945 and that I last saw h[illegible] alive on Feb. 13 1945.

Immediate cause of death	DURATION
Carcinoma (primary) of the breast	Unknown
Due to	
Due to	
Other conditions: Chr. diffuse nephritis arteriosclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: injured at work?

23. SIGNATURE: Thos. P. Thompson M. D. or other

Address: Aberdeen Md Date signed: Feb. 15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01787

Reg. Dist. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: LEVI COULD JENKINS

3.(b) Social Security Number: 220-10-7816

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mrs. Laura Jenkins

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): May 28, 1895

8. AGE: Years	Months	Days	If less than one day
49	8	24	...hrs. ...min.

9. Birthplace: Farmington, West Virginia
(Town, county, and state)

10. Usual occupation: Railroad Engineer

11. Industry or business: U.S. Government

FATHER
12. Name: L.S. Jenkins
13. Birthplace: Morgan Town, W. Virginia

MOTHER
14. Maiden name: Thelma C. Jenkins
15. Birthplace: Elgarden, Maryland

16. Informant: The Surgeon
Address: Aberdeen Proving Ground, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb. 23-1945 (month) (day) (year)

Cemetery or crematory:
Location: Cumberland Md

18. Funeral director: Henry Fanning Sons.
Address: Aberdeen Md.

19. Feb 23 1945 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 February 1945 at 5:17P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 17 February 1945 to 22 Feb 1945 and that I last saw him alive on 22 February 1945

Immediate cause of death	DURATION
Coronary Occlusion and myocardial infarction	
Due to: Coronary sclerosis	
Due to:	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results: Confirm cause of death

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A.D. Hoffman 1st Lt MC
A. D. HOFFMAN, 1st Lt. MC M.D. or other

Address: Station Hospital APG, Md. Date signed: 23 Feb 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01788

Reg. Diat. No. 184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Whiteford
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Whiteford
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Hugh A. Jones.

3.(b) Social Security Number: 008-07-8623

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married.

6.(b) Name of husband or wife: Elizabeth Jones
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Nov. 20 1879

8. AGE: Years: 65 | Months: 2 | Days: 11 | If less than one day: hrs. min.

9. Birthplace: York Co., Pa.
(Town, county, and state)

10. Usual occupation: Watchman

11. Industry or business: Standard Milling Co.

FATHER
12. Name: John F. Jones
13. Birthplace: Wales

MOTHER
14. Maiden name: Susan Poff
15. Birthplace: York Co. Pa.

16. Informant: Elizabeth Jones
Address: Whiteford, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 4 1945 (month) (day) (year)
Cemetery or crematory: Slate Ridge
Location: Delta, Pa.

18. Funeral director: Hubert P. Hawkins
Address: Delta Pa

19. Feb. 4 1945 (Date rec'd by registrar) Carl E. Lynch. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 1st 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 30th 1945 to Feb 1st 1945 and that I last saw h[illegible] alive on Feb 1st 1945

Immediate cause of death	DURATION
Pulmonary Thrombosis	1 day
Due to: Thrombophlebitis Rt. Leg.	2 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Josiah G. Arnett M.D.
M. D. or other
Address: Cardiff Md Date signed: 2/3/45

Evidence for change of age of deceased is shown on FILM No. G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0178)

Reg. Diat. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Rural – Jarrettsville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
same as above
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Rural – Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural – Federal Hill
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Lessner

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Henry Lessner
6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): March 8, 1869

8. AGE: Years	Months	Days	If less than one day
76 75	10		hrs. min.

9. Birthplace: Roller, Carroll Co., Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Lewis Miller
13. Birthplace
MOTHER 14. Maiden name
15. Birthplace
16. Informant: Joseph C. Gostomski
Address: Street, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof: February 6, 1945 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Black Rock, Pa.
18. Funeral director: Jarrett Undertaking Co.
Address: Manchester - Md
19. 2/3 1945 (Date rec'd by registrar) Priscilla Foxwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2, 1945, at 1 00 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to Feb. 2, 1945
and that I last saw her alive on January 26, 1945
Immediate cause of death: Heart Failure — DURATION
Due to: Hypertensive cardio-vascular disease
Due to: Essential Hypertension
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: None — Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Charles A. Jack M.D.
M. D. or other
Address: Jarrettsville, Md. Date signed: 2-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

01790

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Harford

City or town Darlington Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Jan 15 - 1944

Hospital, institution, or street address where death occurred:

R Darlington Inc

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County HARFORD

City or town DARLINGTON

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war WORLD WAR II WORLD WAR I

3. (a) FULL NAME Harry Leon Longfoy.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Myrtle Isabell Longfoy

6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) April 1, 1895

8. AGE: Years	Months	Days	If less than one day
49	10	8	— hrs. — min.

9. Birthplace Thompson's Mills (Town, county, and state)

10. Usual occupation Radio Electrician

11. Industry or business U. S. Navy.

FATHER 12. Name Albion Ramage Longfoy

13. Birthplace Maine

MOTHER 14. Maiden name Ella Helen Beck

15. Birthplace Maine

16. Informant Myrtle Isabel Longfoy

Address Darlington Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 12 1945 (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Ft Meyer Va

18. Funeral director Lee A Patterson & Son

Address Perryville, Maryland.

19. Feb 12 19 45 Irma E Dunbar (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1945 at 3 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 1945, to Feb 9 1945

and that I last saw him alive on Feb 8 1945

Immediate cause of death	DURATION
Coronary Occlusion	12 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L L Shaffer M. D. or other

Address Darlington Md Date signed 2/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2nd)

01791

CERTIFICATE OF DEATH

Reg. Dist. No. 188

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Abingdon Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Abingdon
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Arthur J. Magness

3. (b) Social Security Number: 213-16-9583

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katherine Treadwell Magness

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): April 17, 1866

8. AGE: Years	Months	Days	If less than one day
78	10	19	hrs. min.

9. Birthplace: Abingdon Harford Co Md
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: Charles Edward Magness

13. Birthplace: Emmorton Md

MOTHER 14. Maiden name: Mary Jane Whiteford

15. Birthplace: Abingdon Md

16. Informant: Caroline Magness

Address: Abingdon Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Mar. 3, 1945 (month) (day) (year)

Cemetery or crematory: St. Frances

Location: Abingdon Md

18. Funeral director: Howard R. McComas

Address: Abingdon Md

19. Mar 2 1945 Maria M. Mahaffie
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28 1945 at 830A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-23 1945 to 2-28 1945 and that I last saw him alive on 2-28 1945

Immediate cause of death	DURATION
Coronary occlusion	1 week
Due to: arteriosclerotic heart disease with hypertension	Years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Fred O Hodous M.D.
M. D. or other

Address: Edgewood Md Date signed: 3-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

01792

CERTIFICATE OF DEATH

Reg. Dist. No. 18 1

1. PLACE OF DEATH:

County Harford

City or town Rural Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Rural Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clarence E. McCaee

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 27-1944

8. AGE: Years	Months	Days	If less than one day
	1	12	...hrs. ...min.

9. Birthplace Near Aberdeen md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Milton H. McCaee

13. Birthplace Louisiana

MOTHER 14. Maiden name Emelia Robinson

15. Birthplace Texas

16. Informant Mrs. Milton H. McCaee

Address Aberdeen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 10-1945 (month) (day) (year)

Cemetery or crematory Mt Calvary

Location Near Aberdeen Md

18. Funeral director Henry Tarring & Sons

Address Aberdeen Md

19. Feb. 10 1945 Nellie H Riley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1945 at 6:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Malnutrition	
Due to Cause unknown No further information Lieut. C.W.S.R.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gerald C. Palmer M.D. Deputy Medical Examiner Harford County M. D. or other

Address Bel Air, Md Date signed 2/9/45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

01793

Reg. Diat. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street address where death occurred:
Harford Memorial Hosp.
How long in hospital or institution? 15 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Perryman.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME William S Monk

3. (b) Social Security Number 717-07-5414

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 16 1882

8. AGE:	Years	Months	Days	If less than one day
	62	5	19	..... hrs. ..... min.

9. Birthplace Perryman Harford, Md.
(Town, county, and state)
10. Usual occupation Section Gang.
11. Industry or business Penna. Rail Road.
FATHER 12. Name Robert Monk.
13. Birthplace Md.
MOTHER 14. Maiden name Elsie Williams
15. Birthplace Fla.
16. Informant Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 6-1945 (mouth) (day) (year)
Cemetery or crematory Union M.E.
Location Near Aberdeen Md.
18. Funeral director Denny Janney Sons.
Address Aberdeen Md.
19. Feb. 5 1945 A. H. Lewis M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1945 at 2.00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 21 1945, to Feb 4 1945
and that I last saw h... alive on Feb 4 1945

	DURATION
Immediate cause of death Toxemia	5 days.
Due to Gangrene of foot	1 mo.
Due to Diabetes Mellitus	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles H. Fraser M.D. M. D. or other
Address Harford Memorial Hosp. Havre de Grace Md. Date signed 2-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01794

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 das, 23 hrs.

Hospital, institution, or street address where death occurred:
Harford Memorial Hospital

How long in hospital or institution? 3 das, 23 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Churchville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Aldino Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Lewis Morris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1895

8. AGE: Years	Months	Days	If less than one day
50	0	4	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Sheridan Morris

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Lydia Singleton

MOTHER 15. Birthplace Maryland

16. Informant Howard Morris

Address New Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/22/45 (month) (day) (year)

Cemetery or crematory Rock Run

Location near Churchville Md.

18. Funeral director Penn Funeral Home

Address Havre de Grace Md.

19 Feb-21 19 45 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 19 45, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 16 19 45, to Feb 19 19 45 and that I last saw him alive on Feb 19 19 45

Immediate cause of death	DURATION
Hypostatic Pneumonia	1 day
Due to Fractured skull	
and Intracranial hemorrhage	3 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidents Date of Feb 16

Where did injury occur? Aberdeen (City or town) Harf. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Route # 40

Means of injury Hit by auto driver Injured at work?

23. SIGNATURE Frank Walker M.D. M. D. or other

Address Havre de Grace Date signed Feb 21

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M)

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

01795

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 530 Congress Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Michael Henry Quirk

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Ellen T. Quirk
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6 - 1870

8. AGE: Years	Months	Days	If less than one day
74	6	21	hrs. min.

9. Birthplace Havre de Grace
(Town, county, and state)
10. Usual occupation Filling Station Operator Retired
11. Industry or business
FATHER 12. Name Jeremiah Quirk
FATHER 13. Birthplace Ireland
MOTHER 14. Maiden name Bridget Wall
MOTHER 15. Birthplace Ireland
16. Informant Mrs. Ellen T. Quirk
Address 530 Congress Ave. Havre de Grace
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/26/45 (month) (day) (year)
Cemetery or crematory Mt. Erin
Location Havre de Grace
18. Funeral director Pennington & Sons
Address Havre de Grace Md.
19. Mar. 26 19 45 C. P. Lewis M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 19 45, at 3P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 2/27/45
Where did injury occur? Havre de Grace Harford Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Susquehanna River
Means of injury Fell Over Injured at work? No

23. SIGNATURE Clerkd C Palmer M.D.
Deputy Medical Examiner
Harford County M. D. or other
Address Bel Air Md. Date signed 3/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

01796

CERTIFICATE OF DEATH

Reg. Dist. No. 184

1. PLACE OF DEATH:

County: Harford

City or town: Street Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Harford

~~City~~ or town: Street, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William H. Ratcliff

3.(b) Social Security Number 226-18-9357

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rusha J. Ratcliff

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Dec. 8 - 1877

8. AGE:

Years	Months	Days	If less than one day
67	1	27	hrs. min.

9. Birthplace: Richlands Va.
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER
12. Name: Hezekiah A. Ratcliff
13. Birthplace: Richlands Va.

MOTHER
14. Maiden name: Eliza J. White
15. Birthplace: Belfast Va.

16. Informant: Rusha J. Ratcliff
Address: Street, Md.

17. Burial (Burial, cremation, or removal: Which?) Date thereof Feb. 7-1945 (month) (day) (year)

Cemetery or crematory: Emory cemetery

Location: Street, Md.

18. Funeral director: Hubert L. Harkins

Address: Delta, Pa.

19. Feb. 6, 1945 (Date rec'd by registrar) M. H. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5 1945, at 8:00 ~~A~~ P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1943, to February 5 1945

and that I last saw h[illegible] alive on February 4 1945

Immediate cause of death: Cardiac failure — DURATION

Due to: hypostemion

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Cardiff Md. Date signed 2-6-45

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39)

CERTIFICATE OF DEATH

01797

Reg. Diat. No. 185-

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred: Harford Memorial Hosp.

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Baby Boy Richardson.

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1945

8. AGE: Years | Months | Days | If less than one day: 4 hrs. min.

9. Birthplace Havre de Grace (Harford, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Ralph Richardson

13. Birthplace North Carolina

MOTHER 14. Maiden name Ida Woody

15. Birthplace North Carolina

16. Informant Mrs Ida Richardson

Address Bel-Air, Md.

17. Burial (Burial, cremation or removal. Which?) Date thereof Feb 3 1945 (month) (day) (year)

Cemetery or crematory Harlington Cem.

Location Harford Co. Md.

18. Funeral director H. L. Bailey

Address Harlington, Md.

19. Feb. 2 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1945 at 6 00 P M

21. I CERTIFY that death occurred on the date above stated: that I attended Deceased from 1944 Feb 1 1945 and that I last saw h.. alive on Feb 1 1945

Immediate cause of death Atelectasis — DURATION

Due to Prematurity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Lungs collapsed - Not air contained

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H Trigon M.D.

Address Havre de Grace, Md M. D. or other

Date signed 2-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(WITHIN CORPORATE LIMITS)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

01798

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No. 213 North Stokes St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Frances Richardson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife Robert Richardson (dec.) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 30 - 1866

8. AGE: Years 78 | Months 4 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Daniel Sheridan

13. Birthplace Maryland

MOTHER 14. Maiden name Mabel ?

15. Birthplace Maryland

16. Informant Clarence Richardson (Son)

Address Stokes St. Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/3/45 (month) (day) (year)

Cemetery or crematory St. James C. M. E.

Location Havre de Grace, Md.

18. Funeral director Pennington & Son

Address Havre de Grace, Md.

19. March 3 19 45 C. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 19 45 at 4:33 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 13 19 45, to Feb 28 19 45

and that I last saw h... alive on Feb 28 19 45

Immediate cause of death	DURATION
Acute Pulmonary Edema	
Hypostatic Pneumonia	
Due to Chronic Myocarditis	
Chronic Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley MD
M. D. or other

Address Havre de Grace Md. Date signed 3/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

B1799

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Harford

City or town Bel Air Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Harford

City or town Kelmile

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME mrs mary Sewell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widowed

6.(b) Name of husband or wife Phillip SEWELL

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 7 1868

8. AGE: Years	Months	Days	If less than one day
76			..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Johnson Morris

13. Birthplace Md

MOTHER 14. Maiden name Martha McComas

15. Birthplace Md

16. Informant Mrs Harry Hopkins

Address Bel Air Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/9/45 (month) (day) (year)

Cemetery or crematory Jerusalem Christian

Location Joppa md

18. Funeral director Stonebreger & Gross

Address Benson, md

19. 2/8 1945 Priscilla Fawvor

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1945, at 405 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral hemorrhage	2 wks.
Due to Essential hypertension	
Due to	
Other conditions deabetes (years?)	
Ca breast	8 yrs

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. .....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Jed O Hodous, M.D. M. D. or other

Address Edgewood, md Date signed 2-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

01800

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:
County Harford
City or town Creswell, Bel Air R D # 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Creswell, Bel Air R. D. # 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Leonard Swartz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13 1867

8. AGE: Years 57 | Months 8 | Days 8 | If less than one day hrs. min.

9. Birthplace Abingdon, Harford, Md (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Same
FATHER 12. Name David E. Swartz
13. Birthplace Harford Co. Maryland
MOTHER 14. Maiden name Mamie Gallion
15. Birthplace Harford Co Maryland
16. Informant Mrs Ella Hughes
Address Creswell, Bel Air R.D. #2 Md
17. Burial Date thereof Feb. 26, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Abingdon Methodist
Location Abingdon Md (Cobbstown)
19. Funeral director Howard C. McConnaughey
Address Abingdon Maryland
19. Feb. 24 19 45 Marie M. Mackelfresh
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 19 45, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 44, to Feb 22 19 45
and that I last saw h... alive on Feb 22, 19 45

	DURATION
Immediate cause of death	
Acute Myocarditis	two days
Due to Coronary Thrombosis	
Due to Cardiac Failure	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D.
Address Town of Bel Air Md Date signed 3/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 958

CERTIFICATE OF DEATH

01801

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford

City or town Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph C. Williams

3.(b) Social Security Number 218-03-0435

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Katie Williams

6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) December 16, 1890

8. AGE: Years 54 | Months 1 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace Pylesville, Harford, Md. (Town, county and state)

10. Usual occupation Fireman

11. Industry or business

FATHER 12. Name Henry Williams

13. Birthplace Harford Co. Md

MOTHER 14. Maiden name Lizzie Berry

15. Birthplace Harford Co. Md

16. Informant Mrs. Catherine F. Williams

Address Aberdeen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 19 1945 (month) (day) (year)

Cemetery or crematory St. Marys

Location Near Pylesville Md

18. Funeral director Henry Tarring Sons

Address Aberdeen Md

19. Feb. 17 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1945 at 2 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14 1945, to Feb 15 1945

and that I last saw h.i. alive on Feb 15 1945

Immediate cause of death	DURATION
Acute Pulmonary Edema	18 hrs
Due to Rheumatic Heart Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles H Lyon M.D.

M. D. or other

Address Harford Memorial Hosp. Havre de Grace Md Date signed 2-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01802

Reg. Diat. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days.
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 16 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henry Williamson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 15, 1867

8. AGE: Years 77 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Calvert County, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business On Farm

FATHER
12. Name Henry Williamson
13. Birthplace Calvert County, Md

MOTHER
14. Maiden name Kate Grey
15. Birthplace Eastern Shore, Md

16. Informant Nellie Turner
Address Bel-Air, Md.

17. Burial (Burial, cremation or removal. Which?) Date thereof Feb 17 1945 (month) (day) (year)
Cemetery or crematory Clarke Chapel Cem
Location Harford Co., Md

18. Funeral director H. L. Bailey
Address Darlington, Md.

19. Feb 16 19 45 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1945 at 2 10 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1945, to Feb 15 1945 and that I last saw h.i.M. alive on Feb 15 1945

Immediate cause of death	DURATION
Toxic Myocarditis	4 days
Due to Rheumatic Heart Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Charles W Ligon M.D. M. D. or other
Address Harford Memorial Hosp Havre de Grace Md Date signed 7/15/1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

GIVE CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (100)

CERTIFICATE OF DEATH

01803

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 yrs.

Hospital, institution, or street address where death occurred:

Harford Memorial Hosp.

How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 318 S. Union Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Katherine Deppish Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Harry Scott Wilson (dec.)

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 12. 1875

8. AGE: Years	Months	Days	If less than one day
69	5	28	hrs. min.

9. Birthplace Havre de Grace, Md. (Town, county, and state)

10. Usual occupation House wife

11. Industry or business —

FATHER — 12. Name John Deppish

FATHER — 13. Birthplace Maryland

MOTHER — 14. Maiden name Unknown

MOTHER — 15. Birthplace Maryland

16. Informant Bertha May Rich

Address 318 S. Union Ave. Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/12/45 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace Md.

18. Funeral director Pennington & Son

Address Havre de Grace Md.

19. 2-12 19 45 O. L. Lewis M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 19 45 at 12 25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 to — 19

and that I last saw h alive on 19

	DURATION
Immediate cause of death Fracture skull	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 2/8/45

Where did injury occur? Havre de Grace (City or town) Harford (County) Md. (State)

Injured at home, farm, industry, public place (where?) Street

Means of injury Hit by car Injured at work? no

23. SIGNATURE Gerald C. Palmer M.D. Deputy Medical Examiner Harford County M. D. or other

Address Bel Air Md. Date signed 2/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

D1814

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution? 12 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 Hilson Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Wooten

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1945

8. AGE: Years | Months | Days | If less than one day: 13 hrs. 27 min.

9. Birthplace Havre de Grace, Harford Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden name Cornelia Wooten

15. Birthplace Natural Bridge, Virginia

16. Informant Josephine Wooten - grandmother

Address 216 Hilson St - Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/26/45 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace

18. Funeral director Cemmons Mort & Son

Address Havre de Grace, Md

19. Feb. 26 19 45 (Date rec'd by registrar) A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 19 45 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 23 19 to 19 45

and that I last saw h alive on Feb 23 19 45

Immediate cause of death	DURATION
Due to Prematurity	6 mo.
Due to Birth.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D. (M. D. or other)

Address Havre de Grace, Md. Date signed 2/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (105)

CERTIFICATE OF DEATH

#18115

Reg. Dist. No. 183

1. PLACE OF DEATH:

County: Harford

City or town: Rural - Forest Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Birth -

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Rural - Forest Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Moore Farm

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William Earl Wyatt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Infant

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 9, 1945

8. AGE:

Years	Months	Days	If less than one day
	1	9	hrs. min.

9. Birthplace: Harford Co. Md (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER

12. Name: Arlie Wyatt

13. Birthplace: Smyth Co Va

MOTHER

14. Maiden name: Hazel Idol

15. Birthplace: Smyth Co, Va

16. Informant: Hazel Idol

Address: Forest Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 20, 1945 (month) (day) (year)

Cemetery or crematory: New Watters Mem.

Location: Cooptown, Md.

18. Funeral director: Martin J. Kurtz

Address: Jarrettsville Md.

19. Feb 20 1945 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~Jan~~ Feb 18 1945 at 11:45 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 16 - 1945 to Feb 18 1945 and that I last saw h.. alive on Feb 16 1945

Immediate cause of death	DURATION
Edema of Glottis	
associated with Acute	
Due to: Urticaria	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill Md Date signed: 2/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B1806

Reg. Dist. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Pearl Virginia Zinkhan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Joseph C. Zinkhan
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): March 16 1903

8. AGE: Years: 41 | Months: 11 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: Atkins Smyth Co Va
(Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER
12. Name: Famous Jackson Hanson
13. Birthplace: N.C.

MOTHER
14. Maiden name: Emma Pfuffe
15. Birthplace: Foy; Va.

16. Informant: Joseph C. Zinkhan
Address: Forest Hill Rd. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 26-45 (day) (year)
Cemetery or crematory: Wm Watters
Location: Coolstown Harford Co Md

18. Funeral director: Mahlon E. Rockhold
Address: Jarrettsville Md.

19. Feb 26 1945 Thomas R. Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23, 1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15, 1944 to Feb. 23, 1945 and that I last saw her alive on Feb. 21, 1945

Immediate cause of death	DURATION
Hypostatic pneumonia	1 wk.
Due to: Metastatic carcinoma from right breast	1 yr.
Due to:	
Other conditions: none.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles A. Graf MD
M. D. or other
Address: Jarrettsville Md. Date signed: 2-23-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING